

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION OFFICE
PHYSICIAN'S / MEDICAL EXAMINER'S CERTIFICATE OF DEATH
350 CAPITOL STREET, ROOM 165, CHARLESTON, WV 25301

FILED
048985
STATE FILE NUMBER

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last) James Joseph Bulger Jr.			2. SEX Male		3. SOCIAL SECURITY NUMBER		
4a. AGE (Last Birthday) (Years) 89		4b. IF UNDER 1 YEAR 4c. IF UNDER 1 DAY Months Days Hours Minutes		5. DATE OF BIRTH (MM/DD/YYYY) 09/03/1929		6. BIRTHPLACE (City and State or Foreign Country) Boston, MA	
7a. RESIDENCE (STATE) MA		7b. COUNTY Suffolk		7c. CITY OR TOWN Boston			
7d. STREET AND NUMBER 17 Twomey Court			7e. APT. NO.		7f. ZIP CODE 02127		
7g. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			7h. 2nd LEGAL RESIDENCE - PROBATE USE ONLY - OPT.			7i. APT. NO. CITY OR TOWN COUNTY STATE ZIP	
8. EVER IN US ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			9. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Unknown			10. SURVIVING SPOUSE'S NAME (Give name prior to first marriage.)	
11. FATHER'S / PARENT 1'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) James Joseph Bulger Sr.			12. MOTHER'S / PARENT 2'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Jane V. McCarty				
13a. INFORMANT'S NAME John P. Bulger			13b. RELATIONSHIP TO DECEDENT Brother		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 17 Twomey Ct Boston, MA 02127		
14. PLACE OF DEATH (Check only one; see instructions)							
IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival <input type="checkbox"/> Hospice facility <input type="checkbox"/> Nursing home/Long term care facility <input type="checkbox"/> Decedent's home <input checked="" type="checkbox"/> Other (Specify): Prison							
15. FACILITY NAME (If not institution, give street & number) U.S. Penitentiary - Hazelton			16. CITY OR TOWN, STATE, AND ZIP CODE Bruceton Mills, WV 26525		17. COUNTY OF DEATH Preston		
18. METHOD OF DISPOSITION <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Entombment <input type="checkbox"/> Other (Specify):			19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place - location in Box 20.) Saint Josephs Cemetery				
20. DISPOSITION LOCATION (City, State) Boston, MA			21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY 1101 Bigley Avenue Charleston Mortuary Service Charleston, WV 25302				
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH Dale R. Burger			23. LICENSE NUMBER (Of Licensee)				
ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH			24. DATE PRONOUNCED DEAD (MM/DD/YYYY) 10/30/2018		25. TIME PRONOUNCED DEAD 0904		
26. SIGNATURE AND TITLE OF PERSON PRONOUNCING DEATH (Only when pronouncer IS NOT also the certifier.)			27. DATE SIGNED (MM/DD/YYYY)				
28. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY) Found 10/30/2018			29. ACTUAL OR PRESUMED TIME OF DEATH Found 0821		30. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No IF YES, MEDICAL EXAMINER CASE # 18-6303		
CAUSE OF DEATH							
31. PART I. Enter the chain of events -- diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. Enter only one cause on a line. Add additional lines if necessary.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Blunt Force Injuries of the Head							
Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to the cause listed on line a.							
Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause in PART I.							
32a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			32b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
33. DID TOBACCO USE CONTRIBUTE TO DEATH? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			34. IF FEMALE <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the last year		35a. CAUSE/MANNER PENDING? <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Date Amended		
35b. FINAL MANNER OF DEATH: <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			See 35b. for Final Manner of Death				
36a. DATE OF INJURY (MM/DD/YYYY) Found 10/30/2018		36b. TIME OF INJURY (MM/DD/YYYY) Found 0821		36c. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, office building, wooded area) Prison Cell - U.S.P. Hazelton		36d. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
36e. LOCATION OF INJURY: Street & Number: 1040 Skyline Drive; Bruceton Mills, WV 26525							
36f. DESCRIBE HOW INJURY OCCURRED Assaulted by other(s)							
36g. IF TRANSPORTATION INJURY: SEATBELT RESTRAINT STATUS: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Restraint <input type="checkbox"/> No restraint <input type="checkbox"/> Unknown <input type="checkbox"/> Helmet <input type="checkbox"/> No helmet <input type="checkbox"/> Unknown							
37a. CERTIFIER (Check only one): <input type="checkbox"/> Certifying Physician or Qualified APRN - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Pronouncing & Certifying Physician or Qualified APRN - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner/Coroner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.							
Signature of Certifier Allen Mock Date Certified 10/31/18							
37b. PRINT NAME, ADDRESS, AND ZIP CODE OF PERSON CERTIFYING TO CAUSE OF DEATH (Item 31.) Allen Mock, CME, OCME Main Charleston, WV							
37c. TITLE OF CERTIFIER MD							
38. FOR OFFICIAL REGISTRAR USE ONLY- SIGNATURE OF REGISTRAR Gary L. Thompson			39. FOR OFFICIAL REGISTRAR USE ONLY- DATE FILED 11/14/2018				

BULGER, James J.
NAME OF DECEDENT

DATE/
TIME
OF DEATH
MUST BE
COMPLETED

TYPE/PRINT
IN
PERMANENT
BLACK
INK

STATE/COUNTY
ORIGINAL
FORM VS-002
(Rev. 9/2017)